

An organisational pledge for primary and community care: Improving the treatment and management of asthma in children and young people

**August 2017**

Asthma is the most common long term medical condition affecting children and young people (CYP). 1 in 10 CYP are affected by the condition meaning 240,000 CYP have asthma in London. Many have badly managed asthma – to the extent that 4,000 are admitted to hospital with asthma every year and 170 have such a severe episode that they require admission to intensive care.

At the worst end of the spectrum around 12 children die of this disease in the capital every year. Poorly controlled asthma affects every aspect of children’s lives – their ability to learn, enjoy time outside school with friends or take part in sport. It affects their time with their families and how they sleep.

There are tools and guidance that exist to help healthcare professionals and others treat and manage asthma and support patients to self-care. We do not have to wait for new medicines or a cure for asthma: we need to educate and support our workforce to use these tools to achieve improved outcomes. However, making a significant change requires agreement and coordinated effort.

By signing the “pledge” in this document, this represents an agreement from those in key system leadership positions within organisations to implement simple measures to improve care and management of children and young people with asthma. In addition, in recognition of the significant role played by air pollution in triggering asthma attacks, we are asking NHS organisations to commit to reducing their contribution to air pollution.

To provide support for this, we have produced a toolkit [*NHS Trusts: Air pollution reduction toolkit*.](https://www.healthylondon.org/latest/publications/asthma-air-pollution-toolkit) This describes simple and free changes NHS organisations can make to reduce their contribution to London’s air pollution.

The organisational pledges form part of a wider #AskAboutAsthma campaign being run from **11th to 22nd September**. This is a campaign to raise awareness of simple measures that should be taken to manage all CYP with asthma. It aims to ensure that existing asthma standards and ambitions are met across London and that no more children die from preventable asthma attacks.

In addition to having organisational pledges, individuals will be showing their support for the campaign by describing their own contribution to improving asthma care through the #MyAsthmaPledge initiative.

Both organisational and individual pledges to support the campaign will be visible on the Healthy London Partnership [My Asthma Pledge](https://www.healthylondon.org/children-and-young-people/my-asthma-pledge) page.

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**Key facts (reference [asthma case for change](https://www.healthylondon.org/children-and-young-people/london-asthma-toolkit/primary-and-community-care/evidence-and-resources))**

* London has a higher rate of illness and death in children and young people because of asthma compared to other European countries
* It is one of the top three causes of emergency admission to hospital (4,000 in London each year.) 75% of these admissions are avoidable by implementation of simple interventions
* Nearly half of these children have had an asthma attack in the previous year and 30% have had daytime symptoms in the previous week, but only a fraction of these have a personalised asthma plan on how their asthma should be managed
* 170 children were admitted to intensive care in 2016/17, with an average length of stay of 3 days. The represents a spend of over £1million on intensive care for this population
* Nitrogen dioxide, particulate matter and other forms or air pollution are known triggers for asthma and poor health more widely, particularly in children.
* Around 12 children die of asthma in London each year; 90% of these deaths are preventable. These children should have gone on to lead full and productive lives.

**The need for action in London**

As the most common long term condition in children asthma accounts for one in five consultations with a GP. While London has pockets of world class services for children and young people with asthma, there is unacceptable variation in services, outcomes and patient experience between and across boroughs and from year to year. Hospital admission for asthma is a proxy for failure of asthma management and acts as an indicator of poor symptom management. Emergency admissions for asthma show a threefold variation across boroughs in London. Socioeconomic status, ethnicity and levels of air pollution are all factors in why need and provision may differ, however, variation due to differences in care quality, efficiency and equity needs to be considered and reduced.

**The London asthma standards**

Healthy London Partnership has developed a set of [ambitions](https://www.myhealth.london.nhs.uk/sites/default/files/London_asthma_ambitions_for_children_and_young_people.pdf) for how asthma care should be delivered across the city. [The London asthma standards for children and young people](https://www.healthylondon.org/latest/publications/asthma-standards) bring together these ambitions for London with national and local standards.

The online [London asthma toolkit](https://www.healthylondon.org/children-and-young-people/london-asthma-toolkit/primary-and-community-care/evidence-and-resources) is available to support healthcare professionals, commissioners, schools, parents, carers, children and young people in London implement the asthma standards for children and young people. It has a specific section devoted to primary and community care. The toolkit provides practical resources for all those involved in caring for children and young people with asthma and can be accessed anywhere, at any time.



**Bringing about change – #AskAboutAsthma**

There are **three very simple measures** which if used consistently for all CYP with asthma would have a massive impact on quality of life for these children and young people.

1. The use of a [**written asthma action plan**](https://www.healthylondon.org/children-and-young-people/london-asthma-toolkit/hospital-care/action-plans) drawn up between a clinician and asthma sufferer means people are four times less likely to have to go to hospital for their asthma. Only 28 – 48% of CYP with asthma in London have an asthma plan.
2. Ensuring every child or young person (and their families/carers) understands how to [**use their inhaler effectively**](https://www.healthylondon.org/children-and-young-people/london-asthma-toolkit/pharmacy/inhalers)**.** Less than ¾ of CYP have any form of instruction in how to use their inhalers meaning they may not be getting the full benefit of their asthma medication.
3. An [**annual asthma review**](https://www.healthylondon.org/children-and-young-people/london-asthma-toolkit/primary-and-community-care/review)which will ensure those with asthma have effective regular review of their condition and management

The #**AskAboutAsthma** campaign encourages CYP and their families to ask for these three simple effective interventions to help them control their asthma. In addition, it identifies questions that healthcare professionals should ask of those CYP with asthma to help optimise care

**Bringing about change - system-wide pledges**

In addition to the three simple measures outlined above, improving outcomes for asthma is about leadership, accountability and training in every aspect of asthma care. It requires commitment to an integrated approach and outcomes need to be meaningful and based on meeting the asthma standards.

By aligning our efforts, children and young people with asthma and their families would be diagnosed earlier, would receive better management and experience improved quality of life. There would be less illness and fewer deaths associated with asthma, with less burden on the child, family and NHS as a result.

This agreement is aimed at everyone involved in the treatment and management of CYP:

* GP Federations
* Pharmacists
* Acute trusts (providing emergency and routine care)
* Specialist care organisations
* Commissioners
* Schools

We ask these groups to sign a pledge to improve the care and management of children and young people with asthma through supporting and working towards achieving the asthma standards relevant to them.

As part of this pledge, we ask those who sign up to agree to reduce their own contribution to air pollution that is a significant contributor to asthma in our city. Suggestions of how to do this can be found in [*NHS Trusts: Air pollution reduction toolkit*.](https://www.healthylondon.org/latest/publications/asthma-air-pollution-toolkit)



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GPs, practice nurses and other community health care professionals are a key enabler in the improvement of care for children and young people (CYP) with asthma. They are able to work in new pathways and models of care which are structured, timely and integrated enabling seamless services for CYP with asthma. Pharmacy and schools should be included within future plans and close working with public health and local authorities to ensure prevention and smoking cessation services are accessible.

To ensure clinical leadership for asthma care, each general practice should have an **identified lead for asthma** who helps to develop excellent streamlined processes and best practice for management and monitoring in primary and community care.

The [London asthma ambitions](https://www.healthylondon.org/sites/default/files/London_asthma_ambitions_for_children_and_young_people.pdf) describe system wide goals. [The London asthma standards for children and young people](https://www.healthylondon.org/latest/publications/asthma-standards) bring together the aspirations for London, the NICE Asthma standards, British Thoracic Society guidelines and a number of other key resources

By signing this pledge your organisation is committing to

* implementing the London asthma ambitions and standards for acute trusts
* taking steps towards improving air quality.

Please sign the [pledge document](https://www.healthylondon.org/children-and-young-people/my-asthma-pledge) online or photocopy Appendix A.

You are also encouraged to take a photo and tweet us @healthyLDN about your pledge.



The [London asthma toolkit](https://www.healthylondon.org/children-and-young-people/london-asthma-toolkit/hospital-care) contains numerous resources to support primary care in implementing the standards.

Primary care guide available [here](https://www.healthylondon.org/children-and-young-people/london-asthma-toolkit/primary-and-community/print-version)

The [London asthma standards](https://www.healthylondon.org/children-and-young-people/london-asthma-toolkit/pharmacy) most relevant to primary care are:

All organisations/services\* must have a named **lead responsible and accountable for asthma** (which includes children and young people (CYP). They must also all meet the organisational standards (No 1-7) and patient family and support information provision and experience (No 9-13). Please also the see the workforce education and training standards that are applicable to the provider settings (No 38-42)

* Any new models of care should establish formal partnerships between providers of CYP services and a commitment to work within a multidisciplinary network of care across the pathway that focusses on children with asthma and links providers, commissioners, public health and local authorities with CYP and their families.
* The networks should develop shared pathways, protocols and consider workforce planning.

Please see the *Do you meet the standards* section on the [London Asthma toolkit](https://www.healthylondon.org/children-and-young-people/london-asthma-toolkit)

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| **No** | **Standard**  |
| 14  | NICE Statement 1: People with newly **diagnosed asthma are diagnosed in accordance with BTS/SIGN13 and NICE34 guidance**. |
| 15 | People with asthma who present with respiratory symptoms receive an **assessment of their asthma control**. |
| 16 | People who received treatment in hospital or through out-of-hours services for an acute exacerbation of asthma or wheezy episode are **followed up by their own GP practice within two working days or less** of treatment.If required secondary care follow up is provided within **one month** for every child admitted with asthma and for patients who have attended the emergency department two or more times in the past 12 months. |
| 26 | There are agreed **effective, integrated pathways to ensure the smooth transition between healthcare settings** (i.e. primary care to secondary or tertiary care). These include shared care, referral and discharge protocols between community and specialist and access to prompt specialist advice and help. |
| 27 | People with asthma receive a written **personalised action plan.** (This should be age appropriate.) |
| 28 | People with asthma receive a **structured review**\* at least annually (preferably every three months, depending on severity and clinical need). This must include understanding of their condition and treatment, assessment of adherence, inhaler technique and children’s ACT for those aged over four years. |
| 30 | There is a system to **communicate the name of the responsible** lead / link person caring for child to patients and families. |

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| **#AskAboutAsthma** |
| **Primary and community care should ensure their staff:** |
| **Gps and nurses:**ASK your patients to attend for an asthma reviewASK if the child has been in hospital or UEC care recently? – (Reviews should be carried out after every admission or attendance at ED/UEC)ASK if they understand how to use their medicationsASK about their inhaler technique, check or train all them when they come for their reviewASK about and offer flu vaccination to CYP and their familiesASK about smoking and refer / Offer stop smoking services to CYP or parents/carers |

**Partners in primary care should ASK of the system**

ASK who the practice asthma lead is

ASK if they are able to identify all children with likely asthma, using a prevalence finder or search and call for review annually

ASK if it would be better to use a hub or primary care home model

ASK if their staff are adequately trained and up to date

ASK to engage with local network (include local schools or community support workers where available)

ASK if all your staff know how to recognise asthma and its management

ASK if all your staff use a standardised review template

ASK if system in place to ensure 48 hour review post discharge is done

